JOHN MUIR HEALTH

SCHEDULING COMMUNICATION PREFERENCE

Please Print

PATIENT NAME: _____DATE OF BIRTH: _____

In an effort to guard your privacy while allowing for efficient scheduling, please answer the following questions on how best to contact you regarding scheduling issues.

- ❑ No, it is not ok to leave messages or voicemails.
- ❑ Yes, it is ok to leave messages or voicemails.

Please write all of YOUR contact numbers where we may leave a message:

❑ Home Phone: (_____)_____ ❑ Work Phone: (_____)_____ ❑ Cell Phone: (_____)_____

Persons authorized to receive messages/information at above numbers

_____ _____ _____ _____

Name Relationship Name Relationship

Only the above people will be able to confirm or change your appointment.

Please note: ANY PERSON (including family members) requesting **ANY** information, including appointment confirmations and changes, MUST provide us with 3 points of information about you including: 1. Name, 2. Date of Birth, 3. Zip Code.

Thank you for assisting us.

I authorize John Muir Therapy Center to leave protected health information inquiries that may include the following: Name of patient; Name and phone number of our clinic; Name of treating Therapist(s) or Doctor; Name of referring Doctor; Appointment times and dates; and Scheduling information/requests.

Signature: _____ Date: _____

Relationship, if not patient: _____

1. **Preferred language for discussing healthcare with your provider: _____**
2. **Do you consider yourself of Hispanic or Latino Ethnicity? Yes No**
3. **Which category best describes your race? Circle One**

Asian Black/African-American/African Pacific Islander or Native Hawaiian

Caucasian Native American/American Indian/Eskimo Multi-racial/Bi-racial Other

JOHN MUIR HEALTH

CANCELLATION/NO SHOW/CO-PAY POLICIES

Thank you for choosing John Muir Health for your therapy services. Due to the volume of new patients and limited appointments, we require that you notify our office **24 hours in advance** if you are unable to keep your appointment. We do understand that emergencies arise. In such cases, please contact us as soon as possible to cancel or reschedule your appointment.

Failure to call and cancel an appointment is considered a "No Show." **After two such occurrences, any additional scheduled appointments will automatically be cancelled.** Your therapist will consider you a discharged patient, and will send a note to your physician indicating non-attendance. You will have to contact your therapist to discuss continuation of therapy.

Along with quality treatment, it is the goal of this clinic to treat patients at their scheduled time. If you are more than ten minutes late for your appointment, your appointment may need to be rescheduled.

Co-pays are collected prior to each treatment. Failure to pay may result in a bill from the health system s billing department.

We want to meet the goals of all of our patients and appreciate your assistance. Thank you for your help! Please let us know if there is something more we can do for you.

To cancel or reschedule appointments, please call (925) 947-5300.

Sid Hsu, Director
Rehabilitation Services
John Muir Health

I acknowledge that I have read and understand these policies.

_____ _____

Patient Signature Date

JOHN MUIR HEALTH

CONDITIONS OF REGISTRATION

Consent to Medical and Surgical Procedures: The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or Facility services rendered the patient under the general and special instructions of the patient's physician or surgeon.
Personal Valuables: The Facility shall not be liable for loss or damage to personal property.
Trainees: The Facility conducts training programs for health care professionals. These persons may be observing or participating in the Facility's treatment program. They will be under the direct supervision of licensed professionals. The undersigned has a right to refuse to have trainees participate, at any time, in his/her care.
Consent to Photography: The undersigned consents to photography (still images, videotaping, filming, etc.) for purposes related to diagnosis and treatment or for use in training or education programs.
Release of Information upon Public Inquiry: Requests for patient information must contain the patient's name. The Facility may then, unless otherwise requested by the patient, legal representative, or provider of health care, release at its discretion the patient's condition described in general terms (that do not communicate specific medical information) and the patient's location within the hospital. The Facility will obtain the patient's consent and his/her written authorization to release information, other than basic information, concerning the patient, except in those circumstances when the Facility is permitted or required by law to release information. No information will be released to the public with regards to psychiatric and/or chemical dependency treatment.
Release of Information for Payment: To the extent necessary to obtain payment, the Facility may disclose any portion of the patient's record, including his/her medical records, to any party the patient has identified as liable for any portion of the Facility's charges, including, but not limited to, insurance companies, Health Care Service Plans, workers' compensation carriers, social security administration and peer review organizations. Special permission is needed to release this information if the patient is treated for alcohol or drug abuse.
Financial Agreement: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the Facility in accordance with the regular rates and terms of the Facility. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.
Assignment of Insurance Benefits: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the Facility of any insurance benefits otherwise payable to the undersigned for services rendered at a rate not to exceed the Facility's usual and customary charges. It is agreed that payment to the Facility, pursuant to this authorization, by an insurance company/Health Care Service Plan shall discharge said insurance company/Health Care Service Plan of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned tha the/she is financially responsible for charges not covered by this assignment.
Health Care Service Plans: It is the undersigned's responsibility to know and verify if the benefits contained in the insurance plan agreed to between the undersigned and his/her Health Care Service Plan limit, reduce or deny coverage of medical services at the Facility. The undersigned agrees that he/she is obligated to reimburse the Facility for any deductible, co-payments, coverage penalties, or for any service rendered which is not a covered benefit of his/her Health Care Service Plan at the Facility. For non-emergency services, its is the patient's responsibility to ensure his/her Plan has authorized the requested services at the Facility. The undersigned agrees that denial of payment for lack of an authorization for non-emergent services will be considered a denial for a non-covered benefit, and payable by the undersigned.

The undersigned acknowledges he/she has read and understands the Conditions of Registration and has received a copy thereof. Furthermore, the undersigned is the patient, the patient's legal representative or is duly authorized as the patient's general agent to execute the above and accept its terms.

_____ _____ _____
PRINT NAME: PATIENT, LEGAL REPRESENTATIVE, AGENT **SIGNATURE** **DATE OF BIRTH** **DATE/TIME**

_____ _____ ☐ **Unable to sign**
RELATIONSHIP IF NOT PATIENT **WITNESS**

Acknowledgement of the Notice of Privacy Practice
The undersigned acknowledges he/she has received a Copy of the Notice of Privacy Practices.

_____ _____
DATE **TIME**

_____
SIGNATURE: PATIENT, LEGAL REPRESENTATIVE, AGENT

If no signature of acknowledgement received, describe the good faith efforts to obtain and give reason not obtained.

_____
_____
DATE **TIME** **STAFF SIGNATUR**

JOHN MUIR HEALTH

OUTPATIENT REHABILITATION SERVICES
MEDICAL HISTORY/SUBJECTIVE INFORMATION

Name: _____ Date: _____
Occupation: _____ Date of Birth: _____
Do you have an Advanced Directive? Yes No Overall Health: Good Fair Poor
Residence you live in? (Please Circle): 1 Story 2 Story Board & Care Assisted Living
Do you have any caregivers to assist with your care? _____
Do you feel safe in your home/living environment? Y N
Do you have any cultural/language/or special needs we should be aware of? _____
_____
How did your injury/condition occur? _____
_____
_____
Where is your injury/condition located?
_____
_____
What tasks/functions are you having difficulty doing due to this injury/condition?
_____
_____
_____
What are your goals for therapy? _____
_____
Have you been treated here before or any where else for this injury/condition? _____
* List all medications you are taking (include OTC and herbal medications):_____
_____
_____
* List all prior significant surgeries/operations:_____
_____
_____
* List any drug allergies or latex allergies: _____
_____
* Have you had or do you suffer from any of the following Diagnoses or Conditions?

__ Weight Loss	__ Double Vision	__ Diabetes	__ Difficulty Chewing
__ Hearing Loss	__ Rheumatoid Arthritis	__ Emphysema	__ Difficulty Swallowing
__ Ear Noise	__ Osteoarthritis	__ Nausea	__ Acid Reflux (GERD)
__ Hoarseness	__ Cancer	__ Numbness	__ Chest Pain
__ Kidney Disease	__ Dizziness	__ Heart Problems	__ Osteoporosis
__ Sleep Disturbance	__ High Blood Pressure	__ Spinal Disorder	__ Fainting
__ Heart Attack	__ Gout	__ Depression	__ Asthma
__ Migraines	__ Headaches	__ COPD	__ Epilepsy
__ Eye Strain	__ Broken Bones: _____		

*Summary List Components – Joint Commission Standard IM 6.40

APTA
American Physical Therapy Association

OPTIMAL INSTRUMENT
Demographic Information

1. Date of Birth _____
   mm / dd / yyyy

2. Sex
   1) ____Male
   2) ____Female

3. Race
   1) ____Aleut/Eskimo
   2) ____American Indian
   3) ____Asian/Pacific Islander
   4) ____Black
   5) ____White
   6) ____Other

4. Ethnicity
   1) ____Hispanic or Latino
   2) ____Not Hispanic or Latino

5. Insurance (Please check all that apply)
   1) ____Workers' compensation
   2) ____Self-pay
   3) ____HMO/PPO/private insurance
   4) ____Medicare
   5) ____Medicaid
   6) ____Auto
   7) ____Other

6. Education (Please check one)
   1) ____Less than high school
   2) ____Some high school
   3) ____High school graduate
   4) ____Attended or graduated from technical school
   5) ____Attended college, did not graduate
   6) ____College graduate
   7) ____Completed graduate school/advanced degree

7. Please check the combined annual income of everyone in your house:
   1) ____Less than $10,000
   2) ____$10,000–$14,999
   3) ____$15,000–$24,999
   4) ____$25,000–$34,999
   5) ____$35,000–$49,999
   6) ____$50,000–$74,999
   7) ____$75,000–$99,999
   8) ____$100,000–$149,999
   9) ____$150,000 or more

8. Employment/Work (Check all that apply)
   1) ____Working full-time outside of home
   2) ____Working part-time outside of home
   3) ____Working full-time from home
   4) ____Working part-time from home
   5) ____Working with modification in job because of current illness/injury
   6) ____Not working because of current illness/injury
   7) ____Homemaker
   8) ____Student
   9) ____Retired
   10) ____Unemployed

   Occupation:_____

9. Do you use a: (Check all that apply)
   1) ____Cane?
   2) ____Walker, rolling walker, or rollator?
   3) ____Manual wheelchair?
   4) ____Motorized wheelchair?
   5) ____Other:_____

10. With whom do you live? (Check all that apply)
   1) ____Alone
   2) ____Spouse/significant other
   3) ____Child/children
   4) ____Other relative(s)
   5) ____Group setting
   6) ____Personal care attendant
   7) ____Other:_____

11. Where do you live?
   1) ____Private home
   2) ____Private apartment
   3) ____Rented room
   4) ____Board and care/assisted living/group home
   5) ____Homeless (with or without shelter)
   6) ____Long-term care facility (nursing home)
   7) ____Hospice
   8) ____Other

Adapted/revised in July 2005 and August 2006 and December 2012 with permission of APTA from Guccione AA, Mielenz TJ, De Vellis RF, et al. Development and testing of a self-report instrument to measure actions: Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL). *Phys Ther*. 2005;85:515–530.

OPTIMAL INSTRUMENT

Difficulty–Baseline

Instructions: Please circle the level of difficulty you have for each activity today.	**Able to do without any difficulty**	**Able to do with little difficulty**	**Able to do with moderate difficulty**	**Able to do with much difficulty**	**Unable to do**	**Not applicable**
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Standing	1	2	3	4	5	9
10. Walking–short distance	1	2	3	4	5	9
11. Walking–long distance	1	2	3	4	5	9
12. Walking–outdoors	1	2	3	4	5	9
13. Climbing stairs	1	2	3	4	5	9
14. Hopping	1	2	3	4	5	9
15. Jumping	1	2	3	4	5	9
16. Running	1	2	3	4	5	9
17. Pushing	1	2	3	4	5	9
18. Pulling	1	2	3	4	5	9
19. Reaching	1	2	3	4	5	9
20. Grasping	1	2	3	4	5	9
21. Lifting	1	2	3	4	5	9
22. Carrying	1	2	3	4	5	9

23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: *1. 13 2. 8 3. 14*)

1.____ 2.____ 3.____

24. From the above list of three activities, choose the primary activity you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs* without any difficulty, you would choose: Primary goal. *13*)

Primary goal. ____

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Confidence–Baseline

Instructions: Please circle the level of confidence you have for doing each activity today.	**Able to do without any difficulty**	**Able to do with little difficulty**	**Able to do with moderate difficulty**	**Able to do with much difficulty**	**Unable to do**	**Not applicable**
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Standing	1	2	3	4	5	9
10. Walking–short distance	1	2	3	4	5	9
11. Walking–long distance	1	2	3	4	5	9
12. Walking–outdoors	1	2	3	4	5	9
13. Climbing stairs	1	2	3	4	5	9
14. Hopping	1	2	3	4	5	9
15. Jumping	1	2	3	4	5	9
16. Running	1	2	3	4	5	9
17. Pushing	1	2	3	4	5	9
18. Pulling	1	2	3	4	5	9
19. Reaching	1	2	3	4	5	9
20. Grasping	1	2	3	4	5	9
21. Lifting	1	2	3	4	5	9
22. Carrying	1	2	3	4	5	9

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